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ABSTRACT

This workshop was planned to review the findings of a study on manpower utilization of professional (M.S.W. degree) and nonprofessional social work personnel in mental hospitals and to determine their application to the demands of a changing mental health program. A literature search and questionnaire survey were used to investigate the proportion of professional personnel among social work staff in state hospitals; social work directors' attitudes on how their personnel are used; relationships between attitudes and actual utilization; directors' perceptions of the roles of their personnel in state mental hospitals, and the degree to which the roles are fulfilled; differences between M.S.W. and non M.S.W. workers as to amounts of supervision, consultation, and inservice education received; and ways of using non M.S.W. personnel to relieve M.S.W. shortages while increasing the quantity and quality of social work services. Implications for undergraduate, graduate, and professional continuing education, and for personnel policy, were suggested. (LY)

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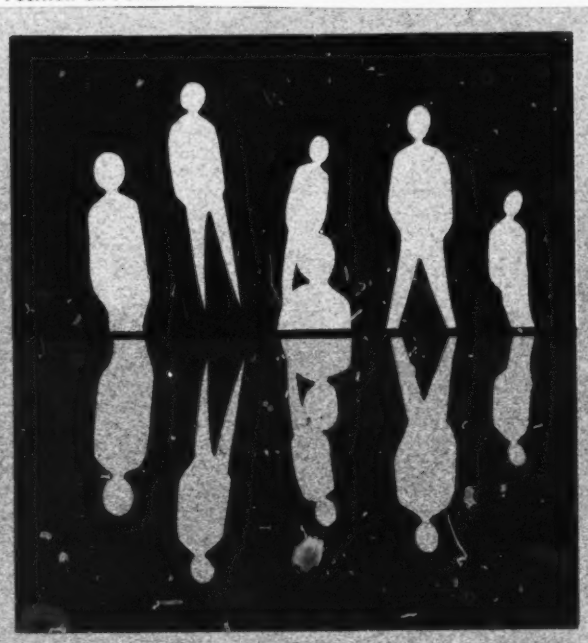
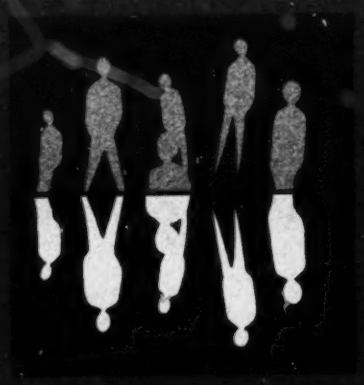


social work manpower utilization in mental health programs



Thomas Carlsen, Editor

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The Division of Continuing Education and Manpower Development of the Syracuse University School of Social Work conducts manpower research, consultation, curriculum development, and offers training programs for all levels of social work personnel. This monograph is part of a series of publications which addresses social work manpower issues.

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social work manpower utilization in mental health programs

PROCEEDINGS OF A WORKSHOP

Edited by
Thomas Carlsen

Manpower Monograph Number Two

The workshop described in this monograph was held at Syracuse, New York, October 10, 11, 12, 1968, and was co-sponsored by the National Institute of Mental Health, the New York State Department of Mental Hygiene and the Syracuse University School of Social Work. Duplication of these Proceedings was supported by contract PH-43-68-01007, National Institute of Mental Health.

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FORWARD

The health service delivery system, its capacities and limitations, are at last a matter of high priority in the concerns of both the public and the professional. It has become important to consider how inadequacies in the system can be remedied; how services can be expanded to reach larger population groups; how the delivery can be made more efficient and less costly; and, how research findings may be applied to reach these goals. These increased demands have mandated that new sources of manpower be found as well as the achievement of better utilization and deployment of all health personnel.

This workshop was planned to provide an opportunity for a group of mental health program administrators to review the findings of a study in manpower utilization of social work personnel in mental hospitals and to determine their application to the demands of a changing mental health program. It also offered the researchers an opportunity for consumer testing and consumer reaction.

While one state mental health system was selected as the base for this exploration, it is the hope that the questions that were raised, the ideas that were shared, and the concepts reflected in these Proceedings will stimulate the interest of other mental health program administrators who are also faced with the need to make differential use of social work manpower and to develop new roles for all staff. It is also hoped that similar challenge will be given to training institutions as they too work toward the solution of the manpower dilemma.

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In attempting to deal with problems related to critical mental health manpower shortages, it has become increasingly apparent that manpower needs can best be met by focusing attention on effective use of people rather than solely on efforts to increase their supply.

Participation in this workshop is illustrative of the commitment of the New York State Department of Mental Hygiene to the promotion of programs designed to improve the uses of mental health manpower not only in social work but in all of the mental health professions and supportive service groups so that the goals of effective treatment and rapid rehabilitation of the mentally disabled may be achieved.

Alan D. Miller, M.D.
Commissioner
New York State
Department of Mental Hygiene

CONTENTS

Introduction..... 1
Thomas Carlsen

Changing Dimensions of Community Health Services:
Challenge to Human Service Professions..... 5
Walter M. Beattie, Jr.

Department of Mental Hygiene - Goals, Needs,
Problems, and Responsibilities..... 13
Summary of Comments by Department Staff

Perspective on Social Work Manpower in Service
Delivery Approaches..... 15
Robert L. Barker and Thomas L. Briggs

Professionalism as an Obstacle to Change..... 25
Thomas Carlsen

Training Implications..... 30
Undergraduate Education
Lester Glick
Graduate Education
Milton Wittman
Continuing Education
Margaret Hoffman

Practice Implications..... 37
Summary of Participant Comments

List of Participants..... 39

INTRODUCTION

Thomas Carlsen
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This workshop is an important outgrowth of a major study of social work manpower conducted by the National Association of Social Workers with support from the National Institute of Mental Health. A comprehensive report of the study is contained in Differential Use of Social Work Manpower by Robert L. Barker and Thomas L. Briggs (New York: National Association of Social Workers, 1968). The major issue addressed by the workshop is the need to disseminate research findings—that facet of responsible research which frequently is underprogrammed or omitted altogether—in the interest of promoting effective utilization of social work manpower in mental health programs.

The National Institute of Mental Health found two willing and enthusiastic collaborators in its quest for appropriate means to broadcast and critically examine the meanings and potential usefulness of manpower research findings. New York State, through its Department of Mental Hygiene, wished to capitalize on emerging knowledge of manpower utilization strategies, and the Syracuse University School of Social Work, through its Division on Continuing Education and Manpower Development, recognized an opportunity to tap research and practice experiences for concepts relevant to social work education. Thus, under the auspices of federal, state, and educational institution resources, participants from numerous New York State mental health facilities joined with mental health administrators and planners from six states in dialogue around contemporary mental health manpower questions.

Major among the objectives of the National Association of Social Workers Utilization of Social Work Personnel Project were: to determine the number of social work personnel in state mental hospitals, their levels of education, and the uses to which they are put; and to identify new and efficient utilization patterns which would minimize the deleterious impact of manpower scarcities on the quality of mental health services. Specifically, the project sought to provide practical answers to the following questions:

1. What is the proportion of professionally trained social workers (M.S.W. degree) per number of staff members on the social work services of state hospitals?

2. What attitude do social work unit chiefs have about how their personnel are utilized, and what is the relationship between this attitude and actual utilization?

3. What are the roles of the social work personnel in state mental hospitals as perceived by the chiefs who deploy the personnel, and to what degree are these roles fulfilled?

4. To what degree are there differences between the amount of supervision, consultation, and in-service training that is given to the MSW workers on the staff compared to the non-MSW workers?

5. How may non-MSWs be utilized in state mental hospital social service units so that they are helpful in resolving the shortages of MSW workers while at the same time increasing the quality and quantity of social work services?

The answers to these questions, as obtained through surveys of the literature and questionnaires returned by 75 per cent of all state hospitals in the United States, are described in Differential Use of Social Work Manpower.

Further data were available from the demonstration phase of the project at Connecticut Valley State Hospital, conducted in cooperation with the Connecticut Department of Mental Health. Following an in-depth functional analysis of social work services within the hospital, the demonstration experiment focused on in-service training which would enable social work personnel to:

1. clearly determine the functions and goals of their service;
2. determine all possible means of fulfilling those goals, rather than confining oneself to traditional approaches;
3. determine who was best equipped to provide the means that would result in goal fulfillment;
4. determine which discrete functions had to be done at the expense of which others in the event of manpower scarcities;
5. work as members of a social work team, with specialists and generalist workers on the team so that non-MSWs could be used more widely;
6. assign activities on the basis of goals to be accomplished rather than basing assignments on cases or tasks; and
7. consider as the client for social work services not merely the patient in the hospital but also his family members, his personal associates, the patients in the hospital as a group, the community which is most vulnerable to mental illness, the staff of the hospital which uses social work services, and the public at large.

There were nine major conclusions drawn from the National Association of Social Workers project:

1. There are approximately an equal number of MSW and non-MSW social workers employed in direct service positions in state mental hospitals. MSWs and non-MSWs are generally used interchangeably with the result that optimum service quality for patients and other client groups is sometimes sacrificed.
2. The supervision, consultation and inservice training for the MSWs was just as extensive, and in some cases more so, than for non-MSWs.
3. Most social service chiefs believed that non-MSWs were only expedient to the MSW manpower shortage and had no unique contribution to make.
4. Of the chiefs (one-third of the total) who believed the non-MSWs had a unique function and purpose, there was a tendency to utilize the non-MSWs in a wider range of functions than did the chiefs who did not view non-MSWs as having unique purposes.

5. Those functions of the social service units which were considered to require less training and skill to fulfill were considered to be among the most important roles of social work by the chiefs. However, the workers spent a disproportionate amount of their time in activities which tended to require more skill and training to accomplish and did so at the expense of the former activities.

6. Attitudes of Connecticut Valley State Hospital social service staff generally coincided with findings of the national survey. However, given in-service training, the social service staff were able to see the consequences of their attitudes and use of personnel.

7. The field demonstration at Connecticut Valley Hospital showed that non-MSW social workers can perform a variety of functions which were previously done by MSW staff members. Activities can be structured, goals of service can be identified, needs can be predicted, and training and supervision can be organized so that non-MSW utilization on a differential basis in teams does not mean lowering of standards. The use of non-MSWs results in a qualitative as well as a quantitative improvement of service in that a wider range of needs were met and the department was better able to respond to the requests made of it.

8. Use of the non-MSW in direct services with patients and other client groups freed the MSW to engage in community mental health planning work. The role of the MSW also changed in regards to greater involvement in consultation, teaching and management activities. The clinical skill of the MSW was more selectively used and his expertise was placed in a broader context as he offered consultation to other team members.

9. The greatest obstacle to the differential use of social work staff is the attitude of the field that the use of non-MSWs is an expedient answer to a "temporary" shortage of MSWs.

The principle purpose of this workshop is to share and discuss the findings described above. Given the nature of workshop participation, a format evolved easily. First, universal health manpower needs are identified, especially in the context of growing emphasis on the development of human service professionals for community mental health service. Next, the manpower dilemma is described for a particular state, that is, New York State Department of Mental Hygiene perspectives on manpower needs, goals, problems, and responsibilities. The central issues raised, highlights of the NASW project are described with special focus on new models for utilization as demonstrated at Connecticut Valley State Hospital and reported in detail in Differential Use of Social Work Manpower.

Central to discussion of the research experience is consideration of the implications for social work practice in mental health. Special attention is given the role of the social work profession as an enhancer or impeder of staff utilization changes. Attention is also given to the relationship of research findings and training programs and policies.

If this workshop has a payoff, it probably will be measured by the degree to which participants analyze the findings of the NASW project and consider their import for selective implementation in education, service delivery, and policy-making. In sum, the payoff will be in the field, in the future and in the increasing sophistication with which we utilize mental health manpower in the delivery of mental health services.

Changing Dimensions of Community Health Services: Challenges To The Human Service Professions

Walter M. Beattie, Jr.
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To discuss the challenges to the human service professions which have arisen through the changing dimensions of community health services, one must first present a view of community health. Such a view must be predicated upon the changing philosophy as to the meaning and goals of health and the characteristics of the health care delivery system. A perceptible trend is the increasing interdependence of medical care and public health. Viability between medical care and public health concepts is underscoring attention on the whole person, within the context of his family, neighborhood and community as the focal point of community health services. Further, it broadens the activities of health care services beyond diagnosis, treatment and restoration to those for prevention of disease, promotion of function, and rehabilitation at all stages of symptomatology.

Other important characteristics of change in the concept of health, giving rise to the broader concept of community health, include a growing recognition of the interdependence of environmental and personal health services. The environmental health concept of the "problem shed" as the geographical area which must be recognized for the solution to specific environmental health problems, and the "community solution" view for the organization of resources to meet personal health needs, lead to the concept of region, as the territorial basis for the planning and delivery of health care services. In fact, there seem to be at present two countervailing foci: one of centralization for planning purposes and for the allocation of scarce health manpower and technology, such as in regional medical planning (heart, cancer, and stroke); and the other of decentralization of direct services to assure access to them. The latter is particularly the situation in inner-cities with neighborhood health service delivery systems. Decentralization is evident in our Syracuse Psychiatric Hospital where the concept of a catchment area is used to define geographically areas of services within the city of Syracuse.

We must also recognize the shifting goals of health care. These may be expressed as comprehensive care, continuity of care and coordination of care services. In viewing these goals, which are seldom realized, the question must be raised whether health agencies and organizations can continue to perpetuate traditional rigidities of service provision, each going its individual way, or whether there is going to occur, as I believe there must, an increasing emphasis on the interdependence of agencies and human service manpower around community health care systems. Three additional concepts must be stressed. These are: that services be accessible to members of a community or geographical region; that they be acceptable, that is, offered in a way which assures their use and which considers the social, cultural, and economic differentials within the population; and, finally, that there be built into the health care delivery system the concept of accountability. The latter implies program audit and includes measures to determine whether or not the goals of health care are indeed achieved.

Throughout the country there is much ferment concerning professional education, whether it be medical, social work, legal or any profession which serves the needs of people. Given the concepts of community health described above, we see developing new models of health care delivery systems which have tremendous implications for the education of practitioners. In the medical area there is increased recognition that specialization in practice and categorization of services are leading to ever increasing fractionalization of care. The question has been raised as to how to integrate care concepts and service components around the needs of the individual and his family. In fact, recent studies and investigations of the changing characteristics of health care services and their implications for professional education, such as the Millis Commission's Report and the reports of the National Commission on Community Health Services, identify the unit of care as shifting from the individual to the family, with the concept of family care increasingly interrelated with the concepts of comprehensive care. Coupled to this are the following: 1) the movement away from solo practice to organized group practice on the part of increasing numbers of physicians; and, 2) a greater emphasis on the development of ways to assure access to the health care system. Educational institutions must instill recognition and knowledge of a single standard of care which emphasizes quality for all in the population and suggests that there will not be special hospitals and care services for the indigent and for other special populations; rather, there will evolve a single health care system accessible to all in the population. To achieve a single system heavy emphasis must be placed on new approaches to education as well as to new financial mechanisms and new strategies for the coordination and allocation of health resources to assure comprehensive and continuous care services of high quality.

Other trends which must be recognized include new organizational forms which are occurring as the health care system is more rationalized. Such concepts include the community mental health center, the community hospital as the health center, and even the health campus, which includes aspects of public health intermingled with medical and psychiatric care services. Another apparent trend is the opening up of medical staff privileges to physicians in the community to assure their access, and that of their patients, to the full range of hospital technologies and specialties.

All of the above implies the necessity for defining levels of care as well as the differential functions of health care facilities and health care manpower within the framework of such definitions. We are beginning to see greater emphasis on concepts of progressive patient care and on definitions such as the teaching center, the community health center, satellite facilities, extended care facilities, etc. Each of these, based upon its particular goal within the overall goals of comprehensive community health services, implies special characteristics, roles, knowledges and skills on the part of health care manpower who are employed in or are related to such facilities. What I am underscoring is that we are beginning to see emerge the rationalization of roles and functions of various kinds of health manpower and definitions of their functions according to levels of skill. This is beginning to occur within social work, and will increasingly be the case for varied professional and allied manpower within the total health care system.

A final trend must be recognized. Rapid changes in practice are occurring due to increasing and expanding scientific knowledge which is the basis of all competent practice. Because of these increases we find newer and more varied kinds of health care manpower and newer organizational

mechanisms for the delivery of services. Also, we must recognize the changing dimensions and characteristics of health needs, such as the shift from acute to chronic illnesses and disabilities, which have placed increased emphasis on the need for manpower trained to carry out early detection and multiphase screening services. We must recognize, however, that as the characteristics of knowledge and services change, and as new needs for health care manpower emerge, there are barriers to such changes. In the professions we must raise the question as to the institutional rigidities which mitigate against new concepts of manpower preparation and utilization. Too often licensure, certification, civil service, etc., while valid when established, fail to change with changing requirements of knowledge and practice. We must question how to preserve quality and the relevance of standards at the same time recognizing that many of the older standards are not delivering "the right service at the right time in the right place."

The many changes in health services have many implications for professional practice. For instance, social work in health related settings must carefully be redefined vis-a-vis the shifting roles and responsibilities of the physician (whether it be psychiatrist, internist, pediatrician, physiatrist, etc.), the nurse, and other key members of the health team. Dr. Benjamin Pasamanick speaks to the changing role of social work in comprehensive mental health programs when he states:

> A few comments are in order on one problem of concern for all the mental health professionals and non-professionals alike, that is, the least possible overlapping in function. Roles should be as clearly defined as possible, with functions as definitive as feasible. It is obvious that some overlapping always will be necessary in order to give complete coverage to patients. But vague, ill-defined, and duplicating roles are unfortunate for the patients, highly destructive of morale in personnel, and dysfunctional in organizations. Studies have shown that under the latter conditions, job satisfaction is low, status rivalry high, decision-making poor and, probably patient benefit impaired. It would seem rational that when professions of differing status and with different amounts of preparation and reward have precisely the same functions in roles in the treatment of patients (i.e., usually individual or group psychotherapy), then the differential status and rewards received become problematic. It is in this context that the role and training of the social worker must be developed. We will need liaison between patient and community, serving as the integrating mechanisms for the patient in his various contacts with social institutions. This function should be primary in the role of the social worker. If the profession does not assume this role, then we will have to develop a new profession for this purpose.[1]

Pasamanick's comments imply expanding roles for social workers as consultants in such areas as social diagnosis and direct service provision, and organization and planning to better meet the needs of individual patients and vulnerable populations. Above all, the professionally trained social worker must be seen as a person to provide shared leadership around social change and social problem solving. With the increasing emphasis on the multi-disciplinary team, we must be careful to recognize the professional knowledge base and skills which are unique to each of the professions if we are to use professionals interchangeably. Further, we must recognize the mutual contributions of the health service professions and allied

manpower in meeting patient care needs, and the limits in the range and content of knowledge and skill of each profession. Finally, we must underscore the fact that all health care professionals, including social workers, must be activists in political and economic decision-making areas where fundamental policy and goal determinations are hammered out.

The paramount question for educators must be: how relevant is our professional education to the need for social statesmanship within the professions? Leadership is sorely needed from all of the human service professions if indeed we are to achieve some of the stated goals of community health care services as well as the goals of professional responsibility.

Specific recommendations of leading national bodies such as the National Commission on Community Health Services[2], with which I was associated, suggest that the functions of coordinating services, technical planning for services, and developing of social supports to medical/psychiatric care are not the province of the physician; unless the social work profession defines carefully the functions for which it is capable of performing in such areas, other professional skills and disciplines will come into being. Let me share with you several of the Commission's position statements which I believe suggest new roles and responsibilities for all human service professionals as we move toward new dimensions of community health services. These include:

> Political considerations raise problems not specific to health affairs, but crucial as the setting for health action. The most significant political issue in community health organization is that of revision of outmoded, overlapping, and ambiguous jurisdictions. Health service administrative areas must be efficiently functional in terms of major health problems and can no longer be circumscribed by traditional community, state, and national boundaries.
>
> The organization and delivery of community health services by both official and voluntary agencies must be based on the 'community solution,' that is, environmental health problem-sheds and health service marketing areas, rather than primarily on political jurisdiction.

Comprehensive personal health services, as pointed out earlier, must not only be available and accessible, but also must encompass the full range of health-related disciplines which enable the public to use their services. The Commission states:

> All communities of this nation must take the action necessary to provide comprehensive personal health services of high quality to all people in each community. These services should embrace those directed toward promotion of positive good health, application of established preventive measures, early detection of disease, prompt and effective treatment, and physical, social, and vocational rehabilitation of those with residual disabilities. This broad range of personal health services must be patterned so as to assure full and intelligent use by all groups in the community.
>
> Success in this endeavor will mean much change. It will require removal of racial, economic, organization, residence and geographic barriers to use of health services by all per-

sons. It will require strengthened and expanded licensure and accreditation of services, manpower, and facilities. It will require maximum coverage through health insurance and other payment plans, and extension of such insurance to cover the range of services both in and out of hospitals. Finally, success will require a citizenry that is sufficiently well informed and motivated to follow established principles conducive to good health, and to cooperate fully with health services in all phases of prevention and treatment of illness and disability.

The Commission further identified the role and place of psychiatric care within the context of broader comprehensive personal health care services.

An increasingly urbanized and complex society has produced its own stress patterns. These call for special psychologic and psychiatric measures in connection with health promotion and health care.

- The psychological aspects of health and disease and the application of social sciences to the health field deserve increasing recognition by the health and other interested professions.

- The importance of environmental stress in causation, and of environmental support of treatment, of psychiatric disorders, should be recognized in the organization of general medical, occupational, social and welfare services.

- Psychiatric services are needed in varying degrees by an appreciable part of those seeking medical care and should therefore be incorporated as part of all aspects of prevention and treatment.

- The current national movement towards 'comprehensive community mental health and retardation service' and the great resources that have been developed (public interest, experience, and money) should be integrated into community plans for comprehensive personal health services.

As noted before, the inseparableness of personal health with the health of the environment is basic to an understanding of changing responsibilities of the human services professions. Environmental health can no longer be viewed in terms of control of hazards; rather, it must be envisioned in the broader context of the environment as a positive or negative force for the physical, emotional and social well-being of the individual. In this regard, the Commission states:

Optimum health can be fostered by prospective planning and management of comprehensive environmental health services. This means going far beyond assuring pure water, clean air, and safe food. It means assuring hygienic housing to provide space for adequate privacy and family sociability, for places of rest and quiet, and places for activity and recreation. It means assuring an external milieu for man designed to stimulate his greatest growth potential.

Planning for a healthy environment is an essential consideration in urban design. Immediate steps must be taken by those responsible for the control of land use, transportation,

economic development, and related physical and social planning to coordinate their activities to: provide for the most effective use of space for our rapidly growing urban population; avoid ill-effects that may be associated with high population densities; reduce hazards to physical and emotional health from overcrowding where it exists; and contribute to an esthetically and emotionally satisfying environment conducive to positive health.

Nearly three-fourths of our population will be urban dwellers during the last quarter of this century. Some sections of the nation, embracing several states, will soon be broad belts of high population density. The urban center is fast becoming the metropolitan area and several metropolitan areas are merging into megalopolis. The effects of so many people living so close together need attention now to prevent those factors that contribute to ill health and to foster those factors that contribute and enhance a better health and life.

Within this broad framework of community health services the National Commission addressed itself to the central issue of manpower, and their numbers and utilization in the health care delivery system. It stated:

Effective utilization of available health personnel will reduce the current manpower shortage, and continuous evaluation of use of manpower, accompanied by necessary changes and retraining, will provide additional manpower for existing and new health services. However, to provide comprehensive community health service in the next decade will require an unprecedented effort to recruit, educate, and train additional manpower for the health team. Such an effort should be intensive, planned, and continuous, and should emphasize team work among all levels of health manpower.

Every community must have available the skills and techniques of many kinds of health personnel. These needs are increasing in terms of numbers of people as well as kinds of skills required. The wide range of manpower for environmental and personal health services includes not only engineers and physicians, but many varieties of laboratory technicians, dentists, nurses, pharmacists, physical, occupational, and speech therapists, homemakers, health aides, social workers, psychological and vocational counselors and nutritionists.

To deliver comprehensive health care, all members of the health team must work together, with each member consistently contributing his most highly developed skills and recognizing others' skills and particular contribution to the health of people. They must, at a minimum, coordinate their work.

Within the broader context of manpower for the delivery of comprehensive health care, The National Commission on Community Health Service specifically addressed itself to the need for increased numbers of social workers in health. It stated:

A new look at the curriculum of the medical school may well serve as the key to the provision of physicians adequately trained for modern medical practice. But this is only the foun-

dation; additional funds and teaching resources are needed in other disciplines as well.

The shortage of trained social workers, for example, is one of the most acute in the health field, and is destined to become even more so as more people over 65 are able to finance health care. Vigorous efforts, voluntary and governmental, must be undertaken to increase the supply of professional social workers in medical and health services through the construction of expanded and new educational facilities; financial support for faculty field instructors and related costs of teachers; fellowships and traineeships; and research and experimentation in methods of professional education aimed at innovations intended to improve the quality of professional education of social workers for medical and health services.

There should be increased training for social workers in medical and health settings, where training is community-oriented and provided in concert with other members of the health team. In addition, since it is probable that graduate schools are not going to produce enough social workers to meet the increasing needs in this field, research and demonstration must proceed toward a teaching program to train personnel of less than professional skills to perform limited duties within the health team.

Additional financing is needed not only for students of social work; to repeat, all qualified candidates for training in a health career should receive the financial assistance they need from government, industry, or other sources—in the form of grants, scholarships or loans—to complete their training.

The implications for social work education of the changing dimensions of services and the requirements for different kinds of human services manpower are many. In social work we see the model of practice increasingly embracing that of problem-solving at the individual, group and community levels. There is a movement away from the more traditional practice model of treatment and remedial service provision to a more public health prevention-epidemioligial model, that is, encompassing prevention of social breakdown and the enhancement of social function. Further, there is an increasing attention being given to the significance of the environment and the manipulation of the environment to enable clients to function.

Curricula for social work education are becoming increasingly diversified in response to the broader requirements of the society while at the same time attempting to individualize its offerings to meet career goals of students. The goal is to develop the capacity within the student for differential assessment of human-social needs and the use of differential methods for meeting such needs. Further, greater emphasis is being placed on helping the student know administrative and managerial skills, particularly in regard to consultive and supervisory responsibilities, including planning and the assignment of priorities.

The emphasis of professional social work education is to help the student learn models of intervention, ranging from basic needs provision to that of systems change. Beyond that the student must be knowledgeable about the formation of social policy and its translation into programs of action. He must know the uses of community and public education, legislation and funding, if he is to mobilize and allocate new resources—manpower, fiscal,

and facilities—as well as modify and allocate existing resources. Here it must be underscored that treatment and direct services provision is still a necessary component for professional practice. It is, however, no longer sufficient to the total task.

We at Syracuse are critically aware of our responsibilities to respond to the need for more social workers with quality education. However, we further see the need for the development of new strategies for the better utilization of existing and new social work manpower in mental health programs. The Syracuse University School of Social Work, in response to the demands of the community has:

1. established an undergraduate division for the human and social services;
2. developed a philosophy statement which is enabling us to redesign the MSW curriculum around social problem-solving tasks;
3. established a Division on Continuing Education and Manpower Development. This division is working closely with the New York State Department of Mental Hygiene in the development of a social work career ladder concept within the comprehensive mental health program; and
4. redefined its Family Service Center agency, with greater emphasis on this agency serving as a laboratory for education and research. This agency works closely with Syracuse Psychiatric Hospital, and the Onondaga County Department of Mental Health and is a focal point in developing mental health services to an inner-city population of disadvantaged blacks and white elderly.

The challenges are many. We believe we have an opportunity to have an impact on manpower needs for community health services. We must work closely with those concerned with the organization and delivery of services to develop relevant strategies to meet mutual needs. In Alice in Wonderland, Lewis Carroll points out, "If you do not know where you are going, any road will get you there." Together, the educators, the providers of services, and the consumers must work to clarify the goals of community health services, the place of mental health within such a context, and the ways of organizing human service personnel to achieve such objectives. The Syracuse School is pleased to participate with the State Department and the National Institute of Mental Health in this workshop designed to clarify manpower needs and to suggest innovative ways to utilize existing and emerging manpower resources.

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[1]Benjamin Pasamanick, "The Development of Physicians for Public Mental Health," American Journal of Orthopsychiatry, XXXVII (April, 1967), 477-8.

[2]The references which follow are drawn from the following publications of the National Commission on Community Health Services: Health is a Community Affair (Cambridge: Harvard University Press, 1966); and Reports of the National Commission on Community Health Services (Washington, D.C.: Public Affairs Press, 1967).

Department of Mental Hygiene-Goals, Needs, Problems, and Responsibilities

Summary of Comments
by New York State Staff

A major goal of the New York State Department of Mental Hygiene is that of implementing a "system of service" concept to bring better health care to the mentally disabled of the state. The concept implies tight integration or full development of services provided directly by Departmental staff and those promoted in the community by both public and private sectors. Obviously, services within the broad mental health system are not divided in the same ways throughout the state; variations in patterns of delivery of service are not a legitimate concern as long as major gaps do not exist and patients receive the service required.

Goals and needs of an organization as diverse as the Department are difficult to articulate. It is more productive to describe goals of organizational units especially as they may be universally applicable. Given the focus of this workshop on social work manpower needs and utilization, the Division of Mental Health may serve as an appropriate illustration.

In this regard many Division of Mental Health problems and goals are related to the size of hospital operations and to the relationships with other service facilities. At present, there is general agreement that the inpatient population of New York State mental hospitals can and should be reduced in number. Considerable progress has been made in the last few years as illustrated by the decrease from a 1955 high of 93,379 to the present 70,728 inpatient population. In fact, during the past year there has been a drop of 7,283 resident patients with the decrease in the patient population during the past three years greater than the total for the previous 11 years combined.

The Division goal is to continue the reduction in the inpatient population to achieve a rate of two state hospital beds per 1000 population and simultaneously to increase the level of clinical staffing. The goal is to reach a ratio of 1.1 clinical personnel per patient within the next five to six years.

To accomplish the goals described above there are three clear needs: (1) changes in the size and distribution of mental health facilities, (2) clarification of responsibility for providing mental health services to all geographical jurisdictions in the state, and (3) modification of staffing patterns, especially to the end of developing cohesive work groups within the service systems.

Recognizing that many hospitals are too large and badly situated relative to service populations, a major goal is to establish smaller, better-placed facilities. The target optimal limit is one hospital for every 750,000 population. Reality factors of course will require modifications, perhaps within a 300,000 - 1,000,000 range.

Division operations must be related to political subdivisions. Hospital service areas probably should coincide with county lines since the Division of Local Services uses such boundaries for program purposes. One major benefit of relating to county subdivisions may be that hospital operations can be related more closely to county mental health boards which are the activating mechanism for Division of Local Service operations.

Within each hospital there will be units which will enhance coordinated mutual efforts between in-patient services and community mental health facilities. Such units would be expected to serve a population base of 200,000. The unit idea highlights the questions: how many people can work together effectively as a group and how many patients can such a group handle? The questions have not been resolved but efforts at solution have suggested a need to define small core roles for staff. Core roles overlap and this fact of life should be recognized and perhaps exploited. Conscious role-blurring can capitalize on the talents, knowledge, and human abilities of less skilled members of therapeutic teams. A major rationale for teams in fact is to make better use of untrained members.

Manpower needs of the hospitals are acute, especially for social work personnel. Despite the introduction of a Career Ladder and vigorous recruitment efforts, the number of professional social workers is still less than desired to meet service demands. For example, while the total number of social work personnel increased from 338 in 1966 to 666 at present, the number of qualified social workers is still only 40 per cent of the total. Implicit in these figures is the need to develop the potential contribution of other social work manpower.

The Department recognizes that expanded educational resources for mental health personnel are basic to manpower solutions and cannot be overemphasized. There is also recognition of the need for staff development and inservice training to be accommodated in Department planning. For example, hospital resources need to include a resident training staff and budgeted funds for tuition and educational leave as well as for consultation on educational and service programs.

The Office of Manpower and Training of the Department is acutely aware of existing shortages and the need for developing the potential of social work manpower resources. Current OMT philosophy is that major emphasis must be placed on staff retention and the development of middle-level or pre-professional jobs within the Department. To this end the new Social Work Career Ladder plan gives an unusual opportunity to strengthen social service units throughout the Department. The Career Ladder is being implemented with recognition that adequate numbers of professional staff must be provided for supervision and training and for social work functions requiring graduate training. At the same time, a significant opportunity is being offered to individuals without graduate training to enter this occupational field, perform important and meaningful social services, and receive training for increasingly more responsible supportive and professional positions.

The mental health manpower dilemma in New York State is probably more typical than unique of health programs across the country. Each system has among its tasks the need to establish goals and objectives, to determine available and required manpower resources, and to define the role of each employee within the total organization. Hopefully this workshop can contribute to our ability to define social work manpower roles, training needs, and methods for improving utilization of available resources and potential working relationships with other mental health personnel in service delivery systems.

Perspective on Social Work Manpower in Service Delivery Approaches

by

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The scarcity of manpower in the professions and technical occupations is one of the most serious problems facing the modern world. What is done about it will largely determine the quality of tomorrow's society and will certainly determine the nature of tomorrow's professions. The answers are needed soon, because each day the professional manpower pool in proportion to need is growing smaller. To demonstrate, the Manpower Report of the President[1] issued in 1967 stated that there were currently 9.3 million professional and technical employees in the United States, but that by 1975 there must be 13 million such employees just to keep pace with the present quality and quantity of professional services. This 40 per cent increase must be achieved in the next seven years, but such an expansion would require costly and laborious efforts at best and the nation does not seem to be in a spending mood. But even if the increases are achieved, it will be insufficient. Society cannot indefinitely afford the kinds of social problems it has experienced in the past few years and needed changes will require much more than simply functioning at present levels. Far more than a 40 per cent increase in professional and technical manpower is the necessary goal.

It is a necessary but unrealistic goal. By 1975, the Manpower Report goes on, five million college graduates are expected to enter the professional and technical occupations. This number could be reduced to a substantial extent if abolishment of student deferments from the military draft comes to full fruition. The Report says that twice as many people must enter the profession as are now projected to keep pace with present needs. Undergraduate and professional schools, however, are simply not capable of absorbing such an increase in such a short time and still maintain adequate training standards.

The situation in social work is typical of all the other professions and is in many ways an even more alarming problem. Government projections[2] estimate that there would be 100,000 professional social work vacancies in the United States in 1970. Still another government report says that by 1975 there will be 178,000 professional social work vacancies.[3] In short, instead of a 40 per cent increase needed in the next seven years, a 300 per cent increase is needed to meet social service demands, and a 150 per cent increase must be achieved in less than two years. The nation's schools of social work currently graduate a little over 4,000 MSWs each year, and this number is only about eight per cent of the present number of professional social workers.

To fill these vacancies, social work must draw from the same limited reservoir of potential recruits from which all other professions obtain their future members. Clearly the competitive position of social work compared to other professions is not a good one and the competition will

inevitably grow more intense as the manpower crisis continues. One indicator of this already is the fact that the percentage of graduate students in schools of social work compared to all graduate students has been going down each year for the past 15 years despite numerical increases in the numbers of social work students.[4] In other words, manpower deficiencies are very serious for all professions, but how much more so are they for those groups which do not even maintain their positions relative to the other professions?

Actually, those charged with recruitment to the professions have been doing a very good job. Evidence for this is the fact that social work schools have been operating at capacity for several years. The major limitation in this regard is that a high proportion of students who have been selected for graduate training have been people whose productive careers in the profession are short lived. Graduate social work students are, on the average, several years older than most other graduate students and thus have fewer productive years ahead of them.[5] Furthermore, the schools have traditionally had a high ratio of women, and the recent trends show that an even higher proportion of women to men is occurring,[6] and many of the women graduates give up professional careers for familial ones. These facts suggest that recruitment could be improved qualitatively rather than quantitatively to better meet the needs of the profession and those served by it. Still, regardless of the efficacy of the recruitment effort the number of entrants to the profession is limited by the limited capacities of the graduate schools of social work. To keep pace with current needs, to catch up with former manpower deficiencies and to increase the services to the level recommended by social scientists, the schools would have to increase their capacities four-fold, or nearly 250 new schools, each as big as existing ones, would have to be founded. Obviously, with all the difficulties there are in organizing new schools or expanding existing ones, there is little likelihood that such achievements will be forthcoming.

Statistics such as these have been cited with such regularity of late that their effect is less likely to arouse the professions than to evoke a response of apathy or dubiousness. On the other hand, there may be some within the professional ranks who are content with the fact that many jobs are unfilled and actually take pride in the fact that a manpower shortage exists. Undoubtedly, part of this stance is generated by the belief that a profession's prestige is enhanced as its popularity grows—as it illustrates to the world that its services are in such great demand that there are too few people to meet that demand. This is particularly true of the newer professions which have not yet achieved a high level of prestige and unique responsibility such as library science, urban planning and social work as contrasted with the more established ones like medicine and law. On the other hand, the more established a profession becomes, the less it is likely to try to end manpower shortages. Among the older professions there is the feeling that greater prestige, income and influence occurs if the requirements for entry into their ranks are extremely stringent and exclusive of most people.[7] This assures a limited amount of competition, a "seller's market," and an assurance for those of the "in-group" that their hard-to-get services will always be in demand. Thus we may witness the paradox of a profession actually contributing to its manpower shortage through raising educational standards, declaring that only certain kinds of personnel can perform certain functions and having these standards sanctioned by custom or law.

Social work is similar to other professions in its quest for greater eminence and as such it is developing a tradition which strives for a great deal of exclusivity. It has sought to restrict full professional status to those

with masters' degrees, and it has long advocated that most positions which provide social services should be performed by those with the graduate degree. Yet all the while it has been raising educational standards, the manpower shortages have become more critical, and there is evidence that society may withdraw its mandate unless the profession is able to "deliver the goods." It is impossible to continually bemoan manpower shortages and simultaneously try to remain a closed shop. In other words, despite the fact that manpower shortages may be caused in part by the profession itself and may serve its "prestige" interests and also that those who would like to do something about it are skeptical that it can be tackled, it is a problem demanding resolution.

There are at least four reasons for holding to the view that the manpower crisis among professional social workers is bad and getting worse. In the first place, despite the proclamation that all social service jobs should be performed by professional social workers, three out of every four social work positions are now filled by those without masters' degrees. Secondly, of those who are MSWs, there is an ever increasing proportion which is moving into private practice positions and into private social agencies, and a declining number who are employed in public agencies where the implementation of social services and requirement for personnel is greatest. Thirdly, social legislation is increasing at a rapid rate, with 50 major bills, each requiring more professional manpower, having been passed by the U.S. Congress since 1960. And finally, it is likely that the full extent of the number of vacancies of MSW social workers is not realized. If an agency administrator feels he needs MSW workers but knows he cannot obtain them because of the shortages, he isn't likely to hold a vacancy for long. Rather he will fill it with one who doesn't possess the master's degree. This, then, is not registered in any survey as a vacancy or as an unfilled agency personnel need. In short, no matter what the statistics say and how alarming they may seem, they actually may be conservative.

But what is to be done about that problem? Obtaining more prestige, more pay, and employing more refined recruitment techniques is not the whole answer because of the inevitable bottleneck in the schools of social work. Attempting to expand the schools is not the whole answer because of limited funds, lack of potential faculty members, and the necessarily slow development that new or expanding schools must undergo. Reducing the time it takes to obtain the professional degree is not the answer, especially in light of the knowledge explosion which has led many educators to suggest that there is not enough time in two years to impart the available findings. If anything, they say, the length of graduate training should be increased. Finding more efficient means of service delivery, through automation, systematizing need provision in such ways as the guaranteed annual income, overhauling the public assistance program, and so forth, is not the whole answer because of the enormous initial costs involved and the general public antipathy to such drastic social changes. Re-educating professional social workers to focus their attention on those activities which are exclusively within their province, rather than giving most of their attentions to those activities which are being met by other professional groups, is not the answer because people are going to work at the kind of job they like best despite exhortation to the contrary. All of these, of course, are partial answers and efforts toward their implementation must occur, but they alone will not suffice. Given their limitations something else must be done.

The most reasonable answer to the manpower problem lies in the systematic utilization of people without professional degrees. Whether to use

non-MSWs in social work positions should be a dead issue, for they are being employed in increasing numbers every year. But the dispute has not ended because of the widespread view that officially sanctioning their utilization in social work will result in a decline in the quality of the services rendered by the profession and the degree of prestige which the profession can muster. The protection of standards is deemed a more important issue than the delivery of service. Many, if not most social agencies, cling precariously to the notion that the non-MSW is merely an expedient, holding his job only until the MSW may be employed. Because he is viewed this way, no attention is given to finding ways of using him to provide many of those needed client services which do not require the skills inherent in graduate training.

If, on the other hand, non-MSWs are eliminated and only MSWs are employed, this generally leads to one of two problems. On the one hand, the MSW may meet all the needs of his clientele, but many of those needs could just as well have been met by persons with far less training. In such a case, the MSW's time is wasted and he is "under-utilized." On the other hand, the MSW may restrict his involvement to only those activities which require the full complement of his skill. But in this instance, in the agency which employs only MSWs, many quite valid social needs of clientele would go unmet. In either case many needed services are not delivered to many needy clients.

If services are not delivered, they are not services at all. It therefore makes little difference about the quality with which the service provision could be provided if people are unable to avail themselves of it. This indicates a high incidence in inequality, and inequality for whatever reason is at odds with social work values. Thus, it is not enough to say that use of the non-MSW will result in a decline in the quality of service provision. Furthermore, no scientifically derived evidence has yet been found suggesting that use of the non-MSW results in a lower quality of service than when exclusive MSW service delivery is provided. On the contrary, the findings suggest that more optimal service delivery occurs when MSWs and non-MSWs work together.[8] This is especially clear when the non-MSW in a social service job has had good undergraduate preparation or when there is a vital inservice training program in his agency.[9] This is not to imply that the MSW is any less essential, but only that he is not exclusively so. Nevertheless, many professional social workers are still not receptive to the obvious conclusion. It is difficult to admit that one's hard-earned professional credentials do not guarantee the highest quality of service delivery.

Probably much of the lack of acceptance for sanctioning the non-MSW utilization is the result of the fear of losing prestige rather than losing quality. Agencies often strive toward full MSW staffing because it enhances prestige and give only secondary consideration to whether such a personnel structure is the most optimal. Those agencies which do use non-MSWs often do so with the rationale that they will soon be replaced by MSWs. They feel that if they don't maintain such goals it is a reflection that the agency has poor standards and that the service it renders is somehow less than adequate. Actually non-MSWs pose a threat precisely because they have not been used differentially—since they have been used interchangeably. What they do is often indistinguishable from what the fully trained professional does. Non-MSWs have been referred to in the field as "untrained workers," a status which is most dysfunctional to the profession, for it implies that persons are engaged in professional activities while at the same time lacking professional educational training. The field has responded to this threat by attempting to eliminate all non-MSWs from the field, rather

than eliminating the position and creating a unique worthwhile challenging role for those without the graduate degree. The question should not be whether to use the non-MSW, but how to use him.

The question of how to utilize non-MSWs is vastly complicated. The trouble is that social service provision is a rather abstract and wide-ranging activity, much more so than that of other professions. The physician, for example, can compartmentalize the patient's tangible physical needs into fairly distinct entities and assign these entities to various personnel such as nurses, X-ray technicians and orderlies. The dentist has developed distinct auxiliary occupations to carry out vital functions such as cleaning instruments and teeth. This frees the dentist to accomplish more complex tasks and only he works on the patient's teeth below the gumline. The gumline thus becomes the unit by which to differentiate the activities which are appropriate for the dentist and his auxiliary personnel. But what is the gumline in social work? What services should be the sole province of the MSW and what can be adequately performed by the non-MSW? Because this question has remained unanswered, it is no wonder that conscientious social workers are skeptical about using non-MSWs. For if there is no differentiation between what can be done by the two groups, then for the protection of the client all the services should be met by the professional. But since there aren't enough MSWs, a way to make a distinction between the work allocations of the two groups is imperative.

But that way is not easily found. More than 200 studies in social work have been published in the past 10 years dealing with this question and the answers haven't yet been revealed.[10] Major attempts were made by two federal agencies, the Veteran's Administration and the Bureau of Family Services of the U.S. Welfare Administration.[11] The Veteran's Administration is the nation's largest employer of MSW social workers and its social service departments were staffed virtually exclusively by professional workers. Then, in 1964, they established an experimental position in selected hospitals for the Bachelor's Degree level person, called the social work assistant. The assistant worked always under close MSW supervision, was viewed clearly as a technician or helper of the professional, and was never given sole responsibility for a case. Specific and rather routine tasks were assigned to the assistant by the MSW in non-sensitive areas of client service. This position was most circumscribed and career incentives generally lacking. In addition to the problem of frustration for the assistant because of career limitations, the major limitation was the use of the task as the unit of differentiation. To divide up social service activities into distinct tasks so that they may be assigned to various personnel requires that some criteria be established about which tasks should be given to which personnel. The criteria presumably must be based on a conception of which tasks are more complicated and which are less so. Who is to say what tasks are too complicated for the non-MSW and makes a task more or less complicated are two unanswered questions. But even if they were answered, the task differentiation has another problem. Tasks go together in clusters, some of which may be very complex and some are less so, and their fulfillment therefore must be accomplished almost simultaneously by the same person. This being the case, it appears fruitless to give different tasks to different workers, no matter how complex or simple they are.

The Bureau of Family Services approach attempts a different route but ends up with many of the same problems. Since public assistance agencies are the largest employer of B.A. level personnel in social welfare, their approach has been predictably quite different from that attempted by the Veteran's Administration. The Bureau developed the concept of two career

lines, one for B.A. personnel, called social workers, and the other for MSWs, called professional social workers. In this scheme the B.A. is considered a member of a distinct occupational group which provides services quite autonomously from the MSW. Thus, the B.A.s could have career advancements, become supervisors and administrators, and not be thought of as ancilliary to the MSW. The system depends upon the ability to determine which cases are appropriate for assignment to the professional social work group and which to the B.A. group. What criteria can be used to suggest which cases are to be assigned to which personnel groups? The Bureau deals with this issue in a most unsatisfactory way, suggesting that people with certain kinds of problems, certain diagnoses, age groups, racial or ethnic backgrounds, and social situations can be categorized and then assigned. And if they could be so categorized, would the allocation be reliable in view of the fact that no illness or situation remains static. And finally, if professional social workers rule out certain illnesses or situations because they were viewed as coming into the province of the B.A. worker, would social work be giving all clients equal treatment and opportunity? Neither the case nor the task unit of differentiation, therefore, seems adequate as a means of differentially allocating the social service job to various personnel groups.

The trouble with such otherwise laudable efforts as the V.A. and B.F.S. approaches is that they, and many like them, begin by attempting to segmentalize the respective jobs of the MSW and B.A. groups without first considering the functions the agencies are to do. The efforts too frequently attempt to find ways of carving up the job responsibilities of the various personnel without giving prior attention to whether the activity is even necessary or not. Beginning with the approach of dividing up a series of responsibilities rather than with the purposes of the organization is getting the cart before the horse. One must start by investigating whether the function is appropriate, and whether the means used to achieve that function is the best, all before attention is given to differentiating responsibilities. Seeking to find optimal use of personnel in any other way would be like trying to build a machine out of many random parts without having any advanced conception of what the machine is supposed to do. This point can be illustrated in the following example. There is a story about a recent attempt to make better use of manpower in the armed forces. Part of the project was to examine current personnel requirements for artillery units. The investigators found that six men were stationed at each field cannon even though they could find jobs for only five men. They were told that six men were assigned because the manual called for that many people. The investigators couldn't understand the discrepancy, so they consulted the author of the manual, an aged retired Army general. "What is the sixth man supposed to do?" The old man replied to the investigators, "Why he holds the horses." The story is fictitious, but it illustrates how the needs of one time might not be the same for another, and the needs of one agency might not be the same as those of another. To avoid such inefficiencies, a constant look at agency goals and the best means of fulfilling them are the only reasonable starting point in any effort to use personnel.

To determine the agency's goals requires a systematic analysis of the organization's functions in which six questions must be answered. These are, first, what are the explicit or stated goals of the agency? Second, which of these goals are most important and which are least important for fulfillment when there is a scarcity of resources? Third, what are the concealed or latent goals which also must be performed in order to enable the explicit agency goals to be fulfilled? Fourth, which of the latent goals are

consistent with and which are inconsistent with the stated purposes of the organization? Fifth, what are the different possible means by which the goals may be achieved? And finally, how are the jobs to be done, differentially allocated to the personnel in the current structure of the agency? When these questions are answered for each agency, the notion of what to do with the various personnel becomes much easier.

Given an understanding of the agency goals, the question still remains how to differentially deploy personnel with MSW and BA level backgrounds while avoiding the problems described. The possible solution which seems to be gaining acceptance to a greater degree each day lies in the use of what is called the social work team. Rather than attempting to isolate the MSW and the B.A. from each other as though their relationship might somehow contaminate someone, the team approach attempts to maximize the close relationship. On the team there is always at least one MSW, the team leader, and usually several non-MSWs. The number of team members depends upon the nature of the agency and the goals to be achieved. In some cases there could be several MSWs, and only one or two non-MSWs on the team, or the proportions could be reversed.

The MSW team leader has the primary job of determining the client need and the best possible way of meeting that need. Usually the leader does not perform the actual activity required to fulfill the need, but assigns it to one or more of the members. This ensures professional involvement for all who are served while it frees the professional from having to engage in all the routine tasks which can just as well be accomplished by the non-MSW. The utilization of those lacking professional education in team operations may alleviate some of the concerns about professional standards and use of sub-professionals. By using teams, with professional judgments and decisions involved at critical points in determining goals and means of carrying out services, one structures into the service delivery system the professional values and know-how which may be lacking in the individual members who comprise the system. Thus, a sub-professional need not have completely internalized the values and philosophical stances of the human services or have mastered the body of knowledge and techniques required of the fully professional practitioner.

The team members would be expected to develop their own areas of expertise and specialization so that each is not a mere duplicate of the other and so that a wider range of skills is brought into play for all services delivered. This specialization and development of expertise could eventually be promulgated through undergraduate training programs, but until that time, inservice training programs could enhance such special skill. The team member thus becomes an expert in his own right, with all the status and career opportunities that go with this. Continuity of services can be achieved through caseloads maintained by team members who enlist the aid of their fellow members when such expertise is required. Flexibility is achieved in a way that can never be in the individual client-worker model.

While the team leader makes the ultimate assignment of activity to the members, most projects which use the team approach recognize the need for some guideline which can be used in deciding which activities are to be accomplished by which team member. In the National Association of Social Workers Utilization of Personnel Project[12] these guidelines are dealt with in the concept of the Episode of Service. An Episode of Service, or EOS, is any cluster of activities that go together to achieve a specific goal in a social agency. It is identified by the goal, but it includes the connotation of all the alternative means by which to achieve it. The means which the team leader chooses to achieve the goal should be the most efficient of those that

the team members are competent to perform. The EOS is assigned to the social work team, frequently by the agency executive, for a specific goal or a long range and indefinite one. The leader then decides how to break the EOS into discrete activities for assignment to the various team members. If they cannot be broken down, then the team members work conjointly on goal fulfillment. For example, the agency is an adoption agency, and the director believes one goal should be procuring more residential facilities for unwed mothers during their early stages of pregnancy, and for obtaining more foster homes to care for infants prior to placement in adoptive homes. Given this EOS, the team leader determines all the means of goal fulfillment—education of the public as to the need, evaluation of prospective residences, obtaining funding from voluntary contributions, and interviewing those who have homes to provide for residential care and interviewing the mothers-to-be to assure satisfaction between the two. The team leader finds he has one team member, a B. A. who has become well versed in fund raising activities for special projects, and another one who is skilled in public relations. These specialists are given the responsibilities for educating the public and obtaining funds, respectively, and each specialist can call on the other team members for assistance during times of special need. Another team member, an MSW, and the team leader assumed the task of interviewing the clients and matching them up. When the agency is satisfied that an adequate backlog of residences are developed, the EOS has come to an end.

In other EOSs the criteria for differential allocation of function between MSWs and non-MSWs may not be so clear. But social work theorists are hard at work at the development of such criteria, and several attempts at this seem to have much merit. One such attempt devised by Levine and elaborated on by the faculty at Syracuse University[13] conceives of social work practice as a series of interventions into the life process of clients for the purpose of enhancing social functioning. The intervention is seen as occurring at four different levels on an ascending order of complexity, but descending order of primacy for survival. The first level, the least complex, is called the "need provision" level of intervention, which includes activities which meet the most basic of human needs such as economic support, shelter, protection, meaningful human relations, and other very concrete social services. The second level is called the "problem-solving and management" sphere and is aimed at blocks which interfere with goal achievement. Included are such activities as providing information about community resources, helping the client to understand the nature of his problem, and helping society to know its responsibility in creating such problems. The third level is called "conflict resolution" and consists of identifying the sources of conflict and assisting the opposing forces to achieve accommodation. The fourth and most complex level is called "systems change" which entails resolving dysfunctional elements in the structure of various systems: individual, family, neighborhood, community. The details of this model makes it more comprehensible and useful, but they are too extensive to cover here. Suffice it to say that the model contains an assumption that differential allocation of social work personnel responsibility can occur based on the level of intervention required. There would always be some overlap but, for the most part, the first two levels could be fulfilled by the non-MSW, and the last two could be reserved for the MSW. Another conception developed by Kidneigh also appears to have possibilities.[14] This model uses a scale for measuring levels of complexity based on such criteria as originality and initiative required, judgment, independence, expressive requirements, and intensity and level of contact

with persons. The point is that there are guidelines and measures by which the team leader can make rational decisions about how to differentially assign his personnel if he only takes the trouble to look into them.

The efficacy of the team approach will ultimately depend upon the ability of the personnel involved to take on drastically new roles and the ability of the educational institutions to train social workers for these roles. The MSW skills will have to give more focus to management activities, consultation, teaching and coordination of other personnel, while the non-MSWs will have to acquire a series of very specific abilities, each of which will be needed in the team activity. If a cadre of B.A.s and other levels of personnel are trained for such vital roles, it can do much to resolve the manpower problem and provide a quality service delivery system for which the profession can take pride.

During the next segment of this workshop we plan to elaborate on the experience at Connecticut Valley State Hospital where we attempted to test some of the ideas presented above. Our hope is to capture some of the highlights of the National Association of Social Workers demonstration project and to stimulate workshop participants to examine the usefulness of all the study findings as they were described in Differential Use of Social Work Manpower.

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Professionalism as an Obstacle to Change

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The usefulness of the concept of the team in mental health service delivery has been touched on during this workshop by many different individuals representing several different professional perspectives. I, for one, have been disturbed by the ambiguity with which we use terms like team, leader and work unit, but am heartened by the fact that we have convened to try to make some sense out of a potpourri of disparate views of professional mental health practice.

Barker and Briggs have suggested that one of the major findings in their study of staff utilization in mental health settings is that more efficient use of personnel can be achieved if sub-professional social work personnel function as part of a social work team. In order to focus and limit my observations I propose that we define team as a social work team and not confuse the issue by attempting to generalize to other disciplinary combinations which form professional health teams. Given this definition it follows naturally that for the purpose of this discussion the team leader is a social worker who leads a professional social work team.

Consider the following question: given a description, or descriptions, of what a professional social work team leader should be, how do we go about obtaining him, and what, if any, are the obstacles to such delivery? My central thesis is that we know very little about what the leader should be or how to obtain him, and that many of the obstacles to attaining such knowledge are rooted in the professionalism of social work. The substance of the question raised is one of role definition of the team leader and training for his specialized roles. These are relatively new and emerging roles and these roles constitute the change referred to in the title of this presentation.

Four points will serve as context for the discussion. First, professional resistance to change, when it does occur, tends to be a cyclical thing. One professional forum, for example, the Delegate Assembly of the National Association of Social Workers, has on several occasions in the past failed to revise membership requirements to admit B.A. level personnel, who, at least in the Syracuse University School of Social Work view, are engaged in professional mental health practice. Such resistance fortunately is time-limited. It is encouraging to note that the combined Council on Social Work Education and the National Association of Social Workers Ad Hoc Committee on Manpower Issues recently has advanced specific recommendations which may provide a breakthrough in the dilemma of appropriate recognition of baccalaureate level social workers.

The second point is that mental health social workers do not differ from other professionals in at least one very important respect: they are plagued by inadequacy of knowledge and theory to accomplish assumed tasks. When we face ideological questions we tend to try to escape into technology. On the brighter side, however, we are experiencing such pressure for change that it is possible Titmuss may be wrong when he concludes we are witnessing the "triumph of technique over purpose." The obstacles social workers create for themselves as professionals are not peculiar to social work. This assumption is of paramount importance to the arguments to be

presented later since they appeal directly for the adoption of obstacle-surmounting ideas developed in other professional quarters.

Third, change obviously is not necessarily eufunctional. Need we go further than to recognize that there are provisions within the 1967 amendments to the Social Security Act which most of us as professionals must abhor. This assumption is critical to the later argument that there are conditions under which change may be decidedly dysfunctional, to the point, in fact, that we should resist and create obstacles to such practice.

Finally, there are situations involving big problems which call for more than limited tactics. Is it possible that our attempts to test the efficacy of team structuring of mental health manpower too often may have taken the form of fragmented, small-scale demonstration? One can be suspicious that generalizable guidelines for training may be inadequate in direct proportion to scope of demonstration effort. As we permit small-scale testing of the effectiveness of new measures to occur, we frequently underestimate training needs and fail to promote training strategies appropriate to the dimensions of the larger problems requiring solution. Are there dangers in applying limited-scale manpower utilization designs to massive manpower shortage problems? Put another way, have well-meaning professional behaviors created major obstacles to use of teams by failing to provide relevant training to personnel on whom the success or failure of the team approach may hinge?

What are the requirements of social work team leadership and how are such requisites met? The following excerpt is from the Family Service Association of America second progress report on the project which utilizes social work teams in working with aging family service clients. Is this edited excerpt a useful description of team leader qualifications?

> The team leader caseworker must be experienced in working with aging clients, and comfortable and skillful in her practice, have a degree of imagination, and be interested in experimenting in the new team service in an effort to define her role and that of the assistant in individual cases. Further qualifications for effectiveness as a team leader need to include the capacity to share, strong motivation and capacity for experimentation, good ability to conceptualize, and, if there has been no successful supervisory experience prior to team leadership, there should be manifest readiness for it.

It is very interesting to note there is no mention of training team leaders but a separate section in the report is devoted to the subject, "Training of the Assistant." Is this exposition typical of attention given to role specification and training for team leadership?

Briggs and Barker suggest from their Connecticut Valley experience that the only two but essential requirements of the leader are that he be a graduate of an accredited school of social work, and a member of the Academy of Certified Social Workers. What do these requisites necessarily have to do with team leadership qualifications? Isn't it valid to claim that one possible consequence of the "transference model" of counseling, the model to which many MSW and other mental health personnel are exposed, is that it makes no room for sub-professionals to be skilled in supervision of sub-professionals or in training people for sub-professional roles. The document Differential Use of Social Work Manpower provides no clear reference to training modalities which lend themselves to imparting "the kind of expertise needed to fulfill most efficiently the goals that are the province of his team."

This shortcoming is not unique to the Connecticut Valley demonstration project. My association with the Midway project on utilization of teams in deploying public welfare social work staff permits me to estimate there is broad concern that much work remains to be done in devising clear leader role definitions for which it is possible to operationalize training procedures. Those of us with team demonstration experience are obliged to contribute to the development of training prototypes. The answers to questions about role definition and training, when they are available, need to be communicated to those in a position to implement.

It may be helpful to speculate briefly about the role and required training for team leadership. When we talk about training and leadership we are in fact talking about training for particular kinds of behaviors, leadership behaviors. But, even though mental health professionals are concerned with the affective domain of patients and clients, we frequently overlook the attitudinal variables associated with staff. Leadership behaviors can and must be differentiated from leadership attitudes, and team leader training must deliberately focus on compatible attitudes as well as expected behaviors.

As an aside it was interesting to note the comment by one of yesterday's speakers to the effect that there is an inequity in the state ladder because some younger professionals are unhappy that their position (presumably salary) is the same as that of the highest sub-professional. The critical question to be asked is whether this unhappiness is reflected in performance. If it is, we have one problem; if it is not, we have another. Most research dealing with professional staff attitudes about pay and other material incentives indicates low morale on this attitudinal dimension is not necessarily associated with low productivity. In fact, some of the highest producers, using the crude measures we have to measure productivity, are professionals who are unhappy about their financial rewards.

The rationale for being concerned with leadership attitudes has been well established in the literature. Time and again empirical investigations have revealed associations between leader attitudes and leader performance behaviors. The important message imparted by attitude-performance research findings is that not all work related attitudes are associated with high performance. Herzberg, Porter, Cumming, Lickert and others have contributed much to our ability to distinguish between work attitudes which are critical to high performance, and those which are less important. In my own research I have been able, in a public welfare setting, to substantiate findings from other quarters which attest to the strong relationship between line staff attitudes about supervisory human relations practices and productivity, as opposed to lack of relationship between performance and attitudes toward supervisory managerial competence.

These comments should not be interpreted to imply that there is a well-developed theory of leadership or managerial motivation. To the contrary, there are many unanswered questions about the usefulness of motivational determinants of leader work behavior. What is clear, however, is that leadership roles and training requirements are sufficiently peculiar so as to cast doubt on the argument that traditional professional training for social work practice is sufficient to staff emerging leadership roles.

It is probably true that a professional community exacts a higher standard of behavior for itself than does the law. In the mental health manpower arena, however, professionals seem to have expended much of their energy in articulating the expected behaviors of sub-professionals, pseudo-professionals, or, if you will, all members of mental health teams other than the professional team leader. This is in direct contrast to efforts in

business and industry in which considerable attention has been given to the training of leadership personnel at managerial and supervisory levels. One cannot help but wonder if lack of specified training for expected team leadership behavior may not explain, at least in part, some of the difficulties we are beginning to note in retaining, and sustaining the performance and morale of social work middle management.

What about professional obstacles to change?

First, recall the assumption that professional resistance tends to be a cyclical phenomenon. This notion is at once a useless oversimplification and a very helpful one, for it may be that one of the reasons social work professionals have been slow to respond to the notion of the mental health social work team is sensitivity to the fact that we have not provided relevant training. Social work will, however, be eminently guilty of creating obstacles if in the fact of inevitable developments such as foreshadowed by the Berlatsky committee report we fail to provide necessary training. We will create insurmountable obstacles if we remain preoccupied with job descriptions and position classification systems at the expense of thinking through how to train leaders to implement our neat work division schemes. There can be no question, if one heeds findings of research related to work groups or team operations, that the most, or one of the most critical prerequisites to success, is the leader trained in group leadership. Dr. Cumming identified the need for cohesion among work groups as an important input in the New York State mental health program. Professional social workers do not, simply by virtue of having the MSW or ACSW, necessarily know anything about insuring work group or team cohesion. The length of the obstacle cycle we create will be measured by our response to clear training needs.

Second, social work is not unique when it retreats into technology, or bows to technique rather than purpose. There is no need to document social work's concern with purpose. Our efforts may seem naive at first; they always do, especially in retrospect. But professional social workers, from the BA level on up, are examining purpose with a steadily increasing degree of sophistication. If failure to provide training is an obstacle professionals have created, it is probably due to the fact that our purposes have been unclear. Our purposes may remain unclear at any given point in time, but this reality must not impede efforts to meet obligations as currently perceived. Several speakers at this conference have specifically identified the need to train social workers as managers, trainers and educators, in order to accomplish currently recognized purposes. It is not necessary to create our own leadership training technology completely from scratch. Such technology exists to be tapped in ways we see fit. The obstacles the profession creates will be measured by the degree to which it expends energy duplicating training technology at the expense of focusing on purpose.

Third, change is not necessarily positive. If by change we mean reliance on ill-trained teams to go about the business of providing mental health services we would do well to perpetuate and reinforce resistance. Our experience suggests there are few things more damaging to clients or patients, or to members of a work group, or to organizational structure or goals, than a work group leader who feels in his bones he hasn't been trained adequately to do his job. Turnover of supervisory staff is a minor institutional problem compared with low morale among team managerial and supervisory personnel. As professionals, the obstacles we create to a fair test of the very promising team concept will be a direct function of the length to which we go in denying leadership the training it requires and probably would welcome.

Finally, there are situations involving big problems which call for more than limited tactics. Is the mental health manpower situation bigger than our efforts to date? A personal observation is that I doubt that the team idea or tactic will ever be relevant to national mental health manpower needs until we demonstrate the work of innovators like Schwartz, Barker and Briggs, Brieland, Rivesman and a host of others, on county, state and national levels. What works at Connecticut Valley Hospital may not work at Binghamton State Hospital. What seems to make sense in the Midway District of Cook County may have little value in Carbondale, Illinois. What sparkles at Syracuse Psychiatric Hospital may fail dismally at Manhattan State Hospital. This plea is not for indiscriminant global demonstration, but rather for demonstration of universal tactics on universal problems. As a researcher, I would resist out of professional concern the wholesale distribution of a faulty concept; but, as a researcher, I must advocate the taking of risks.

The obstacles we create to change will be gauged by the degree of unwillingness we display to test our good ideas on samples truly representative of the problems we purport to address. It must be crystal clear from my comments that I am deeply concerned for the hundreds of social workers across the country who may wake up one morning to learn they are team leaders without training portfolios.

Training Implications

UNDERGRADUATE EDUCATION

Lester Glick
Syracuse University

In the last several days we have heard a lot about social systems. A fundamental principle of systems development and change is that if any component of a system is altered, other components must also alter their functions to accommodate to the first change. The change that this conference may be suggesting is that social work now recognizes that BA practitioners will continue to pervade the social service delivery system and therefore their education should be relevant to this purpose. Subsequently, the total educational process for all levels of social work education will be affected.

If consensus has been achieved in any area at this conference, it probably is that the social service delivery system must utilize various levels of trained staff in order to adequately staff services. If in the future the BA trained worker is to be increasingly used as a means of alleviating the manpower shortage in social work, the nature of baccalaureate education must accommodate to this reality. There will need to be a greater consensus about the nature of the educational processes which the 700 schools which offer one or more courses in undergraduate social service education should provide and assure for their graduates. In addition, the question must be answered as to the nature of in-service training within agencies to accommodate to this reservoir of workers who may come from wide varied backgrounds of education and exhibit various personality characteristics.

I will now address myself to several educational implications which the profession needs to consider as they think about educational processes.

1. Various levels of performance must be explicated which are relevant to various levels of training. In other words, the role must be specified in order to answer the question "Education for What?"
2. The educational process should include three components:
   a. the cognitive, which includes the various bodies of knowledge which are relevant to role performance necessary to perform expected roles;
   b. the affect area which incorporates those attitudes and values which are necessary ingredients for all participants in a social service delivery system; and
   c. skill capacities which are necessary to assure that the BA practitioner can adequately perform according to the expectations of agencies which provide services and clients who receive them.
3. Schools of social work need to develop a comprehensive model for evaluating the inputs into the baccalaureate educational process as well as to follow the BA graduate subsequent to his completion of

his degree. Such a longitudinal study would be able to assist in determining the kind of learning which is educationally oriented and which may be attributed to personality characteristics. Furthermore, there should be an effort made to determine the validity of various types of curricula for baccalaureate education as well as a determination of what is more relevant for in-service training by agencies.

4. If various levels of trained staff are to be used, the concept of a continuum must be developed in education in which various levels of training need to correspond to levels of performance. Social work should avoid an education process at any level that would result in a job description which is terminal. Therefore, some conceptual model needs to be developed to permit the use of various levels of trained staff including the volunteer, the community college graduate technician, the BA person, the MSW, and the doctoral graduate. For each of these there should be appropriate tasks and educational activities to complement these tasks. Syracuse University School of Social Work has conceptualized such a model of intervention for each of the corresponding educational levels. In this model the technician and the BA worker provide concrete simplistic services generally on a needs providing level. In addition, the BA worker should be equipped to enter into various problem solving tasks and have a beginning understanding of conflict resolution and systems development and change. The MSW expertise should include middle management skills as well as providing specialized kinds of services in needs provision, problem solving, and conflict resolution. He also should develop an expertise of practice in settings involving systems development and systems change. The social worker on the doctoral level should be able to research social problems and perform the top level management, administration, and education processes. Other conceptual models might also be developed which may be similar to or different from this aforementioned scheme.

In conclusion, I would like to suggest that baccalaureate education should include three tiers of education.

The first tier should consist of the liberal arts, or those offerings frequently called general education courses in the arts and sciences. In this tier an emphasis should be given to communications and the nature of the emerging service professions with special emphasis on the exploration of social work as a career choice.

The second tier should include an emphasis on the behavioral and social sciences as the knowledge base upon which social service concepts are built. This tier would draw from sociology, psychology, economics, political science, and anthropology.

The third tier should include educational activities particularly relevant to the social services and might be called the professional component of the baccalaureate education. In this area the concept of the social services should be introduced along with a conceptualization of the meaning of intervention as well as a direct exposure of the student to field practice in a social agency.

Baccalaureate education should also permit the student to learn about himself and the opportunities within the field of social work as a basis for his making a decision about his career. If his baccalaureate education can perform this screening role there will be a much lower attrition rate for

persons who go directly into employment as well as for those who continue their education in graduate schools.

Finally, labels or titles need to be developed which indicate and explicate a level of education and the corresponding role in practice. The technician might be called an "ancillary" social worker, the BA worker an "associate" social worker, and the MSW utilizing the title of "social worker." I have no compulsion on these explicit titles, but I am certain that we would do a service to the profession by agreeing upon designations.

If the field of social work is able to complete these aforementioned tasks, we will go a long way to solve the manpower problem and to professionalize social work in a way that the future of social work is assured.

GRADUATE EDUCATION

Milton Wittman
National Institute of Mental Health

My assignment was to discuss training implications, and I assume I can define training implications as involving more than just the National Association of Social Workers manpower project. I would like to examine some facets of the study and then move on to consider broader implications for graduate social work education, using as baselines some of the general ideas discussed at this conference.

Barker and Briggs have written, "if present trends persist, the profession may not," at least in mental hospitals. This is an interesting admonition which we all must keep in mind because of the very penetrating questions which are raised. The questions are concerned not only with hospital populations and staff, but also with community mental health centers. In fact, as Dr. Levine rightfully reminds us, the questions are about the whole fabric of our social system. The study also raises some very good questions about education for practice at various levels, and as a matter of fact, concludes on an injunction that the field must reconceptualize the whole continuum of social work education, junior college, undergraduate, graduate and doctoral levels of study in light of redefinitions of practice roles.

While the focus of this conference has been on the BA level practitioner, I would like for a moment to comment on the highest level of the continuum, the graduate doctoral programs. It is interesting to note that in New York there is only one training program at this level. Doesn't this seem strange for a state this size? While we all recognize that doctoral social work programs require large expenditures of resources, they are important in providing the high level leadership needed by the field.

On undergraduate education I have very little to add to the thoughtful comments of Dr. Lester Glick. I know we are all pleased with the leadership that is being provided by the Council on Social Work Education. Their most recent publication Undergraduate Program in Social Welfare will aid the development of undergraduate programs immensely. I think it is only fair to point out that the field lacks clarity as to the purpose of undergraduate education. Some see the baccalaureate level as the proper point for education aimed at preparing persons for beginning positions in social work. Others view undergraduate programs as providing only liberal arts background for graduate study in cases in which professional training will follow. The debate is still going on.

A more recent source of social work manpower has been the emerging programs at the junior or community college level. Donald Feldstein of the Council on Social Work Education staff has studied this development and reported it in Community College and Other Associated Degree Programs for Social Welfare Areas. The Council plans to develop guidelines for such programs and offer assistance in strengthening these programs. This is a most encouraging development.

Turning to Masters' level education: there is a great deal of ferment of which you should be aware. Schools are not standing still; they are re-examining objectives and their accomplishments. Many of the faculties are restless, seeking new ways of training, and, in particular, have made an assault on the traditional practice methods orientation. There are attempts being made to teach multiple methods in the field and to enable students to have an exposure to all three traditional forms of practice, i.e., casework, group work, and community work. The results are encouraging.

Contemporary poverty programs have had an obvious impact on both mental health programs and graduate social work education. The neighborhood service center concept, which is now a common mold for delivery of services in many large cities, raises questions about linkage. How do mental health programs link to service centers? What is the role of the social worker in the new relationship? We need to think carefully about these questions in order to plan relevant graduate curricula.

In addition, graduate training has taken on a greater "community orientation." The pressure of OEO programs may be a determining factor in this trend. The "comprehensive movement" dating from Kennedy legislation has forced us to examine whether we have applied common public health knowledge in the area of social service provision in terms of both prevention and service delivery. This question is what is puzzling many schools. How do you translate the comprehensive philosophy into educational philosophy? We may be somewhat negligent in terms of persistently bringing to educators the experiences of the field. Many are beginning experiences but they are, nevertheless, important.

Perhaps we can learn something from the State comprehensive mental health plans now on file. They are interesting reading because the states and territories have tried to survey and gain perspectives on needs in the mental health field. However useful these documents may be, the point is that we need much more data for educational planning. Unless the curricula do reflect the impact of poverty program philosophy and the comprehensive movement in education in the 1970's, Barker and Briggs' prediction may become a reality.

I particularly am interested in the last two of the 20 social work functions described in Differential Use of Social Work Manpower—research and training. Do we appreciate the significance of the fact that workers, chiefs and administrators alike rated the educational function for social work at the bottom? After meeting with a small group of the chiefs present at this conference, I understand why chiefs rate concrete service as the primary function. I can understand the pressures of the patient population, and the pressures generated in recent years by greatly increased rates of intake and discharge. Nevertheless, I am distressed by the reluctance or inability to undertake educational functions. One function, at least at first, should be to encourage systematic feedback to training institutions. If graduate or undergraduate social workers are not delivering in accordance with the needs of today, are you communicating this to faculties? How will educators know whether curricula are relevant to system needs if you do not evaluate and communicate your findings?

Dean Beattie began this meeting with a powerful appeal to mental health administrators and educators to use modern science in our work and in the educational processes we employ. I interpret this injunction to mean in part that we need continuous evaluation of our efforts, and that these efforts should be systematized. I wonder, for example, whether we can defend the national curriculum study practice of the past—isolated studies of the interrelationship of the application of knowledge and the transmission of knowledge. Perhaps we need to think about ongoing information collection systems and planned periodic national curriculum surveys.

The choice of tactics may be debatable, but the goals of social work education are not. At least they are not in the sense that the educational process must deliver manpower prepared to meet contemporary mental health service needs.

CONTINUING EDUCATION

Margaret Hoffman
National Institute of Mental Health

Continuing education is operationally defined by the Continuing Education Branch, a new branch in the National Institute of Mental Health, as "any education for individuals who are on the job, and have met basic job requirements for entry into work at any level." These individuals include the volunteer, the indigenous worker, the BA level worker, the MSW, and post-masters social worker. We are concerned about basic education, but the Branch does not have responsibility for education which is full- or part-time basic training or which prepares persons for a new career line.

Changes in training technology and occupational structures have far-reaching implications for continuing education after individuals are on the job, both for the individuals themselves and for agency or institutional administrators. This is particularly true for the non-professional, non-MSW worker. An important objective of the continuing education program, one which has specific relevance to the manpower problem, is to develop strong programs of continuing education for all levels of personnel of the four core disciplines, for allied professionals and non-professionals, and for sub-professionals and citizen groups.

The Branch has been in existence two years, and has identified a number of program priorities. The first priority is the development of training centers. Training centers can be university-based or based in other training settings such as a community mental health center. The program emphasis which is indicated for training centers is that an organizational plan be designed that offerings are not just part-time staff development programs conducted by part-time faculty and staff. The part-time training person really is torn in so many ways. Recognition of this fact led the Branch to conclude that training personnel should have full-time responsibility. Here at Syracuse University there is a full-time position in the School of Social Work for the program of the Division of Continuing Education. Fourteen schools of social work now have full-time positions, some of which are funded by NIMH. About half of them, including Syracuse, are funded by the universities. University funding indicates commitment on the part of the university to adult education, or, if you prefer, extension education, but certainly to continuing education. That commitment ordinarily leads to expertise in the process of adult education as a method of training.

The second priority is for implementation of continuing education in mental health settings. All of you are familiar with the NIMH Support Programs including those for hospital staff development which used to be called in-service training programs. There is some grant-in-aid help for training within hospitals, but there remain many questions about the kinds of continuing education which should be offered in mental health centers, for example, and how such programs might best be funded.

The third priority is for projects within existing continuing education programs which have a program development emphasis. North Carolina, for example, has developed cooperative relationships between continuing education in the Department of Mental Health and the University of North Carolina Department of Psychiatry. Contracts have recently been signed, we are told, which also involve continuing education relationships with the School of Social Work and the Public Health Department of the Medical School. The various disciplines will be moving into joint and interlocking responsibilities, and it is hoped the benefits will be felt across the State. In one North Carolina program there is now a project for administrators of community mental health centers. It is an in-residence program in which potential administrators as well as current community mental health administrators are teamed. The administrators already functioning are helping to teach in the two two-week workshops and at the same time they are learning because one can't teach without at the same time being in a reciprocal learning relationship. The new and potential appointees are obtaining a firm theoretical background. All the states in Region IV are represented in the program, a development which reflects the commitment of the States as well as a school to continuing education.

Turning now from priorities, I would like to discuss program organization. To encourage a properly designed program is to think and plan carefully and comprehensively and to consider university and agency linkage. Are the universities, the departments of mental health and the hospitals really working closely together? Linkages are important, especially in situations in which NIMH gives some support to various departments or divisions within a university or training center. Sound planning is essential. There must be representation of consumer interest in such planning through the potential trainees themselves and/or through advisory committees. Financial commitment should also be apparent. Finally, evidence that the continuing education program is an integral part of the department or school is necessary. This means that if there is a full-time person, he should be visible. He should have responsibility at a high level of policy-making in order to have an effect on the program.

It is also very important to involve the learner. We use the word consumer repeatedly; the learners as consumer must be involved as potential participants in all relevant phases of program-planning and development. For example, the Branch has received as many requests for multidisciplinary grants as for unidisciplinary grants. The interesting thing about some of the multidisciplinary requests has been that the school, department, or agency has identified what it considers to be the learner needs, regardless of the discipline of the various consumer groups. There are two nurses and at least two representatives from the other disciplines on the Training Grant Review Committee. Each discipline thus has a representative to evaluate the application on the basis of consumer or learner needs.

In closing I would like to repeat two words we have heard repeatedly during this conference: objective and goal. They are essential concepts in whatever frame of reference they are used. In relation to continuing education, the goals and objectives of the program must be identified clearly

in order to allow evaluation. The committee on continuing education thinks that there must be continuing assessment of the effectiveness of programs in order to insure continuing funding. Evaluation need not be highly sophisticated research, but at least there needs to be feedback to the funding agency to insure cross-fertilization of sound continuing education efforts.

Finally, we have heard much about the continuum of education at this conference. I strongly urge that "continuing education" be added to the undergraduate-graduate-postgraduate continuum to insure comprehensive training for all levels of mental health personnel.

Practice Implications

Summary of Participant Comments

A major conclusion generated by the workshop was that mental health program administrators are and must be increasingly aware of the wide range of possible models for effective utilization of social work manpower. The National Association of Social Workers project experimented with a single model. Conference participants quickly identified the fact that professional practice administration must relate staff utilization strategies to a multitude of program goals, organizational structures, and resource availability, that is, must choose discriminately from many models in various combinational and permutable forms.

The state of California illustrated the process of tailoring staff role specifications to organizational needs. A Social Work Associate position was established by the Department of Mental Health in 1968 after deliberate consideration of personnel needs and experiences. In general, the California Department had not been subjected to MSW shortages as severe as those reported in other parts of the country. Further, department policy precluded use of BA personnel in MSW positions, and major personnel efforts at the MSW level had focused on the critical problem of retention. Development of social work roles for the BA individual was viewed as significant for the following reasons: (1) anticipate possible future manpower needs, (2) allow more appropriate use of MSW personnel, (3) free selected resources for service expansion, and (4) contribute to the development of the emerging BA job market. Drawing on extensive summer experience with college students, the California planners sought to devise means by which the BA practitioner could supplement rather than supplant MSW personnel, and to introduce the concept of the BA social worker at all points of the mental health care continuum—from admission through discharge.

In Vermont, on the other hand, the number of social work positions in the Department of Mental Health organization is small by comparison, and the principles underlying staff utilization may differ. A fundamental concept in the Vermont system is program flexibility, and from this stems the necessity for all staff, including BA social workers, to be educated to understand and aid in the development and implementation of program goals. In order to optimize program flexibility and effective staff utilization the program director must rely heavily on personal judgment regarding the "fit" of individual worker and program requirement, must recognize that legislation and personnel policies are only guidelines to be used discerningly to solve problems, must desist from being overly concerned with role overlap, and must understand that effective staff functioning requires role understanding as much if not more than role definition. A key tactic employed by the Vermont department is that of staff interchanges for periods of from two to six weeks.

The circumstances of shortage of MSW personnel and program administration demands combined to result in yet a different BA staff utilization experience for the Pennsylvania Department of Mental Health. Philadelphia State Hospital was faced with the need to decrease its census by almost 20 per cent in a very short period of time, and required staff who could serve as community reference people, that is, help patients release ties

with the institution and form new ties in the community. Capitalizing on extensive experience with non-MSW personnel in community work, especially in rural sections of the state where recruitment is difficult, and recognizing that individuals with public assistance work experience would be familiar with appropriate community resources, the Department and Hospital collaborated with the County Board of Assistance to form a new service unit. The Community Socialization Service, staffed primarily by BA personnel, including a substantial number with public assistance experience, established a record of sufficient effectiveness to warrant consideration of the formation of similar units in other parts of the Department program.

Social work staff deployment experience in Illinois suggested it frequently is necessary to effect administrative reorganization to accommodate differential manpower utilization. The answers to questions about appropriate work organization and personnel deployment must evolve from program definition. It is not possible to ask the right questions until program goals have been articulated. Given goal clarity it becomes possible to consider questions of optimal work group size, leadership requisites, training requirements, sources of job satisfaction, etc.

Several recurrent themes emerged from discussion of staff utilization experiences in the several states. First, it was clear the workshop participants subscribed to the proposition advanced by Commissioner Miller that "manpower needs can best be met by focusing attention on effective use of people rather than solely on efforts to increase their supply." Recruitment remains a pressing problem but increasing attention is being focused on retention and appropriate use of available personnel. Second, mental health administrators are more concerned than in the past with developing criteria by which it may be possible to match particular program needs with particular staffing solutions. Clearly, BA social worker deployment and the use of social work teams are only palliatives if not employed discriminately according to program goals and needs. A third major departure from the past may be that professional social workers recognize the futility of attempting to identify wholly generic roles for either the MSW or BA practitioner. The question of what all BA or MSW personnel can do no longer has practical validity.

The major issue addressed by this workshop was the effective utilization of social work manpower in mental health programs. More specifically, workshop participants focused on the role of the administrator in resolving some of the problems encountered in full utilization of manpower resources. The importance of the social work administrator's responsibility for planning and management and the need for ongoing program consultation and staff development activities were evident throughout the discussions. The workshop highlight was that it became clear that as much attention needs to be given to the changing role of the program administrator as to changing programs, staffing patterns, and other staff roles if the mental health manpower dilemma is to be challenged realistically.

List of Participants

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